

ADOLESCENT SIBLING PREGNANCY PREVENTION PROGRAM
COMPREHENSIVE BASELINE ASSESSMENT

Intake Date ___/___/___

CMC Code _____

SS# ____-____-____

Client ID #: _____

Sibling of: _____

AFLP **X** Cal Learn **X**

I. DEMOGRAPHICS

1. CLIENT DATA

Name (First, Middle, Last) _____

Age _____ DOB ___/___/___ Sex: **M** **F** Ever married: **Y** **N**

Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Phone (____) ____-____ Message Phone/Pager (____) ____-____

Client's Ethnicity (self-identified) _____

Minors

List name and address(es) (if different from client's)

Biological Mother: Name _____ Work # _____ Home # _____

Address _____ City _____ State _____ Zip _____

Biological Father: Name _____ Work # _____ Home # _____

Address _____ City _____ State _____ Zip _____

Legal Guardian: Name _____ Work # _____ Home # _____

Address _____ City _____ State _____ Zip _____

Relationship to Client: _____

Emergency Contact: _____ Relationship to client: _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Household:

List below individuals who live in the home with the client:

Name	Relationship	Age	Last Contact	Involvement

Language:

	Client	Household
Primary Language(s)		
Language(s) spoken at home		
English Proficiency	Speak Y N Read Y N Write Y N	Speak Y N Read Y N Write Y N
Interpreter Needed	Y N	Y N

2. BASIC NEEDS

Client's financial source(s) of support _____

If client is on Cal Works (AFDC), name of payee _____ Case # _____

Housing Type _____ # of times moved within last 6 mos. _____ Time at this residence _____

Does client ever run out of basic needs (food, rent, utilities) Y N If yes, what does s/he do?

Transportation: ☒Public ☒Own Car ☒Parent ☒Other_____ Adequate: Y N Explain: _____

☒ Valid Driver's License # _____ ☒ California I.D. # _____

Who does the cooking? _____

What is the client's sleeping arrangement? _____

How safe does client feel in the home and where s/he lives? _____

Comments _____

II. PSYCHOSOCIAL

1. ASSESSMENT OF RELATIONSHIPS

Parent(s) / Guardian (s):

Who is raising the client? _____

What is the current relationship with the person who is raising the client? _____

Parent's relationship with client (If different)? _____

P/G's relationship with sibling(s)? _____

P/G's response to sibling's pregnancy? _____

P/G's response to sibling's child(ren)? _____

2. SUPPORT SYSTEMS AND USE OF TIME

Who are the significant people in the client's life? _____

Who helps the client and how? _____

Does client have a best friend or group of friends? **Y** **N** If yes, list first name(s) and age(s) _____

What kinds of things do they do together? _____

How does client spend most of her/his time after school? _____

How does client spend most of her/his time in the evening? _____

How does client spend most of her/his time on the weekend? _____

What are the client's favorite activities? _____

Is the client involved in any volunteer work? **Y** **N** If yes, what does s/he do? _____

Does client like to read? ☒ Yes What about? _____

☒ No Why not? _____

What does the client read? ☒ Newspapers ☒ Magazines ☒ Books

☒ School Work ☒ Pamphlets ☒ Others: _____

How often? ☒ Daily ☒ More than once a week ☒ Once a week ☒ Seldom

Does the client feel OR has the client ever been told s/he has a problem with:

☒ Reading ☒ Yes ☒ No When; by whom: _____

☒ Hearing ☒ Yes ☒ No When; by whom: _____

☒ Vision ☒ Yes ☒ No When; by whom: _____

Does the client watch TV? ☒ Y ☒ N How much and what? _____

Does the client listen to music? ☒ Y ☒ N Favorite group and types of music? _____

Does the client play video games? ☒ Y ☒ N How often? _____

3. CLIENT'S ROLE IN FAMILY AND PERCEPTION OF TEENAGE PARENTING

“What is it like in your home since your sister/brother had a baby?” _____

“What are things like for you since your sister/brother had a baby?” _____

“How much time do you spend with your sister's/brother's baby and how do you feel about it?” _____

“What do you do when you spend time with the baby? How do you feel about it?” _____

“What does being a parent mean to you?” _____

“Do any of your friends have children now?” _____

“How would you feel if you got pregnant (or got someone pregnant)?” _____

“Do you want to be a parent someday? **Y** **N** If yes, then how old do you want to be when you have your first child?” _____ Why? _____

4. BOYFRIEND/GIRLFRIEND

“Are you currently in a romantic relationship?” **Y** **N** If no, then go to next section _____

“How long have you been together romantically?” _____

“Do you spend time alone together?” **Y** **N** “If yes, what do you do?” _____

“What kinds of things do you do together?” _____

“What do you like most about being in this romantic relationship?” _____

“What do you like least about being in this romantic relationship?” _____

“Does he/she ever physically, sexually, or verbally hurt you?” **Y** **N** If yes, how? _____

“Do you know where to get help?” **Y** **N** Where: _____

III. SEXUALITY

1. SEXUAL ACTIVITY & FAMILY PLANNING

What are the client’s thoughts, feelings, and expectations of sexual activity, including ‘doing it’ _____

Has the client ever been sexually active? Explain _____

How old was the client the first time? _____

Is the client sexually active now? _____

If client has had or is having any sexual activity:

During the past month, how many times was client sexually active? _____

How typical is that? _____

Did client have more than one partner in the last month? _____

How typical is that? _____

Does the client ever feel pressured to be sexual when s/he doesn't want to? _____

MALE CLIENTS ONLY:

Is someone pressuring the client to get someone pregnant? **Y** **N** If yes, who? _____

Has the client ever wanted to get someone pregnant? **Y** **N** If yes, explain _____

Has the client ever gotten someone pregnant? **Y** **N** **Not Sure** If yes or not sure, explain _____

FEMALE CLIENTS ONLY:

Has the client started menstruating? **Y** **N** If no, go to next section, if yes, age at onset _____

Are the client's menstrual cycles regular? **X** Yes **X** No

Has client ever been pregnant? **Y** **N** **Not sure** If yes, how many times _____

Is someone pressuring the client to get/be pregnant? **Y** **N** If yes, who? _____

2. USE OF BIRTH CONTROL:

Is client using birth control? **Y** **N** If yes, continue. If no and **not** sexually active, go to next section. If no, and sexually active, explain why _____

Present: Type(s) _____

Consistency _____ Success _____

Past: Type(s) _____

Consistency _____ Success _____

Feelings about birth control _____

Are you comfortable with your current method? _____

Partner's Feelings _____
Provider _____
Sexual Activity/Birth Control Comments _____

IV. EDUCATION EMPLOYMENT LEGAL

1. EDUCATION

School _____ Type/Program _____

Grade _____ Attendance _____ ☒ Regular ☒ Irregular

Expected date of graduation ____/____/____

If dropped out, date ____/____/____ ☒ Grammar ☒ Middle ☒ High School

Reason for not attending school _____

Reentry Assistance: ☒ ☐ Explain _____

Curriculum Counseling/Advocacy Needs ☒ ☐ Explain _____

Please finish this sentence: "To me, finishing school would mean . . ." _____

What does client like most and least about school? _____

What has been client's experience with school? _____

Favorite school staff person _____

School(s) attended in the last 4 years _____

Special needs (check all that apply): ☒ Speech ☒ ESL ☒ Hearing ☒ Vision

☒ Problems regarding reading/writing ☒ Learning disability/problem ☒ Other

Does client need assistance in locating an education program? _____

Do the client's parents/family encourage him/her to go to school? How? _____

Who is home after school? _____

Career goals: Short Term _____ Long Term _____

Comments _____

2. CAREER/EMPLOYMENT

Short term career/education interests _____

Is client looking for work: **Y** **N** If under 16, does client have work permit: **Y** **N**

Has the client ever been interviewed for a job? **Y** **N** Explain _____

What kind of career training/education would the client be interested in receiving? _____

Has client ever been employed? **Y** **N** Is client currently employed? **Y** **N**

Long-term career interests; any idea of what client would like to do in the future _____

Does anyone in the client's home talk with him/her about careers? _____

If currently employed, complete the following

Employer _____ Job _____

Start Date ____/____/____ Work Schedule _____

Comments _____

3. LEGAL

Has the client ever had any trouble with the law? **Y** **N** If yes, explain _____

Has client been on probation? **Y** **N** If yes, explain _____

If yes, name of Probation Officer _____

Has anyone in client's family/household been in trouble with the law? **Y** **N** If yes, explain _____

Has client or family ever been involved with Child Protective Services (CPS) / Family Court?

Y **N** If yes, explain _____

Comments _____

V. HEALTH

1. GENERAL HEALTH

Client's medical history _____

Disabilities _____

Does client have or is client being treated for any long-term illness? **Y** **N** If yes, explain _____

Hospitalizations **Y** **N** If yes, explain _____

Has client received treatment in ER? **Y** **N** If yes, explain _____

Family History _____

Immunizations current? **Y** **N** **Unknown** If no, reason _____

Medical insurance _____

Doctor _____ Frequency of visits/Last visit _____

Reason _____

Average no. of hours client sleeps per night _____

Does client think physical activity is important? **Y** **N** Why / Why not? _____

Does client participate in regular physical activity? **Y** **N** If yes, what kind & how often? _____

Does client take vitamin/mineral supplements? _____

Does client take medication? **Y** **N** If yes, explain _____

Does medical provider know? _____

How often does client get sick? _____ With what? _____

What medication does client take when sick? _____

Does client take home or cultural remedies when ill? **Y** **N** What? _____

Has client told his/her doctor? **Y** **N** _____

Dental insurance _____

Dentist _____ Frequency of visits/Last visit _____

2. NUTRITION

Client's Current: Height _____ Weight _____

History (24-hour recall) _____

Was this typical? **Y** **N** If not, what is a typical 24-hour diet? _____

Is client on a special diet? Explain _____

Currently dieting? **Y** **N** Past history of diets? **Y** **N** If yes, explain _____

Does the client ever make her/himself throw up after eating? **Y** **N** If yes, explain _____

Meals usually eaten: Breakfast AM Snack Lunch Snack
Dinner PM Snack Other: _____

Foods usually eaten each day: Meats Dairy Breads/Cereals/Grains
Prepared Diet Drinks Fruit Vegetables

Beverages usually consumed each day: Milk Fruit Juice Water Soda
Sweetened drinks Wine Beer Coffee Tea Other: _____

How often does client eat junk food? _____ What? How much? _____

General Health/Nutrition Comments _____

3. SEXUALLY TRANSMITTED INFECTIONS (STIS)

What does client know about STIs (genital herpes, syphilis, genital warts, gonorrhea, chlamydia, etc)? _____

Where did s/he get most of the information about STIs? _____

Does client know how to go about getting tested for HIV/AIDS or other STIs? **Y** **N** _____

Would client like to know how to get tested? **Y** **N** _____

Has client ever had STI(s)? **Y** **N** **Not sure** If yes, has the client received treatment? **Y** **N**

Comments _____

4. SUBSTANCE ABUSE

Drug	Age of first use	Last use	Current use (w/in last month)	Amount	Comments
Alcohol					
Marijuana					
Cocaine, Crack					
Meth (Crank)					
Tranquilizers					
Heroin					
Inhalants					
Prescription / Over the Counter					
Tobacco (smokeless/chew/dip)					
IV Drug Use					
Other					

Has the client been exposed to second-hand smoke? **Y** **N** _____

Do the client's friends use drugs? If yes, type(s) _____

Please complete this sentence: "The scariest drug experience in my life was . . ." _____

5. MENTAL HEALTH

Has client ever received counseling? **Y** **N** If yes, explain _____

What was one of the client's best times of his/her life? _____

What was one of the client's worst times in his/her life? _____

Client's description of self _____

What does client do when s/he has a problem? _____

Has client ever had any difficulty sleeping or sleeping too much? _____

What are some reasons why you may have difficulty with sleep? _____

Has client ever had a loss of appetite or eating excessively? **Y** **N** If yes, explain _____

Does client ever feel lonely? **Y** **N** Why/when? _____

Has client ever thought it might be better if he/she weren't around? **Y** **N** Why? _____

Has client ever felt like hurting her/himself (cutting, hitting, biting, killing)? **Y** **N** If yes, describe/explain _____

Has client ever put her/himself in a position where someone would/could hurt her/him? **Y** **N**
If yes, describe/explain _____

Has client ever felt like physically hurting someone else? **Y** **N** If yes, describe/explain _____

How did client handle that? _____

Mental Health Comments: _____

6. SAFETY / ABUSE / HIGH RISK BEHAVIOR

Environment: How safe does client feel with boyfriend/girlfriend, with family, in neighborhood, at school? _____

Has client ever run away? **Y** **N** If yes, explain _____

Has client ever been homeless? **Y** **N** If yes, explain _____

Does client “claim”? **Y N** If yes, explain _____

Does anyone in client’s family “claim”? **Y N** If yes, explain _____

Do any of your previous boyfriends/girlfriends “claim”? **Y N** If yes, explain _____

Does current boyfriend/girlfriend “claim”? **Y N** If yes, explain _____

Do any of client’s friends “claim”? **Y N** If yes, explain _____

Has client ever experienced any of the following:

Physical Abuse: **Y N** If yes, when/what happened? _____

By whom _____

Did client tell anyone? **Y N** Who? _____

Reported to CPS / Family Court / Law Enforcement: **Y N** If yes, when, explain _____

Emotional Abuse: **Y N** If yes, when/what happened? _____

By whom _____

Did client tell anyone? **Y N** Who? _____

Reported to CPS / Family Court / Law Enforcement: **Y N** If yes, explain (list dates) _____

Sexual Abuse: **Y N** If yes, when/what happened? _____

By whom _____

Did client tell anyone? **Y N** Who? _____

Reported to CPS / Family Court / Law Enforcement: **Y N** If yes, explain (list dates) _____

Did client ever hurt an intimate boyfriend/girlfriend, a member of her/his family, or anyone else?

Y N If yes, when/what happened? _____

Whom did client hurt? _____

Was medical help required or received? **Y N**

Was law enforcement involved? **Y N**

Other intervention required or received? **Y N** If yes, what? _____

Has client ever traded sex for money, drugs, food, or a place to stay? **Y N** If yes, explain ____

Comments _____

Signature of Case Manager _____ **Completion Date** _____

IV. PARENT(S) / GUARDIAN(S) SECTION

(Gather this information from the parent or guardian if they are available)

Lodestar # _____

Is this family: ☒ Single parent/ guardian ☒ Two parents/guardians

☒ More than two adults in home acting as 'parents'

1. QUESTIONS CONCERNING THE CLIENT

Hopes and expectations for (the client) _____

What is relationship like with (the client)? _____

2. GENERAL FAMILY ISSUES AND RELATIONSHIPS

How do you feel about being a parent? _____

What is it like parenting a teen parent? _____

How have things changed since teen(s) had a baby? _____

How would parent feel if the other child(ren) also becomes (became) a teen parent? _____

Ask parent to complete following sentences:

"I talk to my child(ren) about _____

"I am the happiest when my child(ren) _____

"It disappoints me when my child(ren) _____

Kinds of things parent does with her/his child(ren) _____

Does parent attend school meetings/activities? **Y** **N** If no, why not? _____

Does parent have a support system/someone to turn to when s/he needs help? **Y** **N** If so, who? _____

Two-Parent Family:

Who disciplines the children? _____

Single-Parent Family:

What role does the other parent have with the children? _____

Is this parent happy with the level of involvement of the other parent? _____

What is the role of the custodial parent in the client's life? _____

Comments _____

Signature of Case Manager _____ **Completion Date** ____/____/____